WHO-WTO Secretariat workshop on differential pricing and financing of essential drugs, Høsbjør, Norway, 8-11 April 2001

Session II - The Role of Financing in Ensuring Access to Essential Drugs

External assistance and pharmaceutical financing

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DG Development
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Europe could be a major force in helping to ensure access to affordable pharmaceutical products to confront diseases, to improve health and reduce poverty. But the potential is not yet the reality, Europe can only do this in partnership with others. I want to put forward proposals on how we could move forward. They are based on the Communicable Diseases Programme for Action adopted by the Commission last February and the ideas we have elaborated since.

Never before the gap between rich and poor has been as massive as to date. The immorality of wealth and poverty side by side is clear. Never before there has been such need for urgent action and collective effort. All of us present here today are individually accountable for what we can do to take stronger national and international action against the diseases affecting the poor. Each of us must be prepared to make radical changes and find the courage to be bold.

One of five of us lives in extreme poverty. The global population will increase by 2 billion people to 8 billion in the next 25 years. By then, 90% of the world population will be living in developing countries. Why should we, international institutions from industrialised countries, focus our ambitions on only 10% of the world's population? It does not make sense.

We should ask ourselves: Are we serious about the international development targets set out by the UN conferences, to tackle poverty around the world? Can we really reduce the proportion of people living in extreme poverty by half by 2015, will all children attend primary school by then? Will infant and child mortality rates be reduced by two-thirds, and maternal mortality ratios by three-quarters? Will all have access to reproductive health services and will the loss of environmental resources have been reversed?

I would say the answer is yes, we are serious and the key objectives covered by those targets remain valid. We might need to adjust the indicators, given demographic transitions between now and 2015 but we are on track to achieve these targets. Enough evidence shows that we cannot achieve systematic and sustained poverty reduction without economic growth. But economic growth is not enough. We need growth and equity.

We must act on education, we must act on health. We know all too well the cost, human and economic, of communicable diseases in developing countries. Malaria, tuberculosis and diarrhoeal diseases kill 8 million people a year. In South Africa, Botswana and Zimbabwe, half of all 15-year olds are expected to die of AIDS. In sub-Saharan Africa, where AIDS and malaria are the leading cause of death, AIDS and other diseases will cut the GDP of some countries.

These are frightening figures. But let us not forget that these diseases are also preventable and prevention and care are intrinsically linked. Access to affordable pharmaceuticals is essential but not sufficient.

– Millions of HIV infections could be prevented through well-targeted, low cost prevention and care strategies;

– As much as half of all malaria deaths could be prevented if people had access to diagnosis and drugs that cost less than half a Euro;

– A quarter of all child deaths could be prevented if children slept beneath USD 4 bednets. In Africa only 1% of children do;

– Millions of lives could be saved by tuberculosis medicines, which are 95% effective and cost as little as USD 10 for a six-month treatment.

Where these strategies have been implemented they have brought results. The latest UN figures show that, however limited their resources, poor countries that make prevention and treatment a priority can stem the spread of HIV and AIDS as Uganda, Thailand and Senegal have, and cut TB deaths by 50 percent as China, India and Peru have done.

In developing countries private expenditure on medicines constitute up to 70-90% of total pharmaceutical expenditure as compared to an average of about 40% for OECD countries. Not surprisingly, of the global sales of pharmaceutical products, sales to the developing world constitute about one fifth and sales to sub-Saharan Africa only about 1%. It is also likely that most of these sales are made among the richest 10% of the population in developing countries.

There is more that developing countries can do to reduce disease and access essential and key pharmaceutical products: yet there is a natural limit imposed by the economies in those countries. Health in developing countries remain heavily under-financed. Non-LDCs increased the per capita health expenditure between 1990 and 2000, but the expenditure in African LDCs fell to an average of just over USD 8 per person (1998). Public health expenditure in many LDCs makes it impossible to finance even the most essential services, including medicines. Raising additional funds for public sector spending from domestic sources is only possible to the extent that economic growth increases total GDP. Realistically achievable financing for health from public and private domestic sources in such countries is likely to increase with 5% to ultimately reach USD 15 per capita per year. WHO estimates that at least 4-5 times more is needed to cover basic health needs. Tiered priced medicines for poorer countries could increase better health outcomes but additional resources will be needed.

Making a real difference for people infected by the three major communicable diseases in Africa alone, would require USD 12-15 billion per year, in addition to the current ODA spent on health. HIV/AIDS prevention and basic care programmes in Africa need at least USD 3 billion a year. The current lowest cost of triple therapy drugs for treating HIV/AIDS at about one dollar a day - an offer made public by an Indian generic producer. But this would still require a total of USD 7.5 billion a year to treat people infected by HIV in Africa. For malaria, USD 1 billion a year is needed to make a real difference, and for tuberculosis USD 1 billion spent on drugs could mean that 70% of new cases could be treated resulting in a 50% reduction in mortality over the next five years.

Total ODA for health, including HIV/AIDS, is in the order of USD 5 - 6 billion annually. The world spends about USD 5-10 million on AIDS vaccines that are specially designed for developing countries. The International AIDS Vaccine Initiative (IAVI) estimates that it would cost USD 350-500 million to develop an AIDS vaccine for world use by 2007. Even with the substantial donations made by major private foundations we are far from breaching these enormous gaps.

National governments and international agencies are responding by affording a much greater priority to health improvement in their policy approaches and resource allocations. In addition to recognising the importance of investing in health development and including greater access to affordable drugs, there is now a greater understanding of how these investments can be made in order to maximise their impact.

There is a growing international consensus that development strategies, to improve health, will require the following:

1. A more substantial and longer term commitment of resources by governments and international agencies;

2. A recognition of the need to ensure that developing country partners are fully included in decisions regarding how these resources are allocated and invested;

3. A recognition of the importance of investing in activities at international level that complement and augment investments at national level (such as research and development of public goods, purchase of essential drugs and vaccines, addressing licensing/trade inequalities relating to pharmaceuticals);

4. A demonstration of strong political commitment to national development, with the formulation of nationally defined/owned development and poverty reduction strategies and a recognition of the importance of ensuring disease reduction objectives are well integrated across development programmes;

5. Support for the development of health systems that are situated within sound sectoral policy frameworks, relate closely to other public service developments and benefit from reliable resource allocations in the medium to longer term;

6. A strengthening of the level of co-operation between all partners and a wider representation of civil society the definition and implementation of health programmes;

7. A recognition of the need to augment investments in developing sustainable health systems with intensified programmes aimed at addressing priority endemic diseases such as HIV/AIDS, malaria and tuberculosis.

There has been considerable progress in ensuring these principles have expression in the development programmes of governments and international agencies. Many African countries have developed, or are in the process of developing, national development policies, which are centred around comprehensive strategies of poverty reduction as detailed in the Poverty Reduction Strategy Papers. These provide a locally defined and driven framework within which governments, development agencies and other important organisations can situate their development contributions. The PRSPs are specifically drawn for debt relief, which I will come back to in a second.

Much progress has been made also in improving the level of dialogue between these respective organisations and in improving efficiency through co-ordination of these contributions. In a number of African countries, for example, governments and development agencies have incorporated recognised principles of good aid practice into the aid methodology of Sector Wide Approaches or SWAps. In these countries a SWAp has been undertaken as a means of reforming and developing the national health system.

On the international scene there is, to say the least, confusion over how best to respond to the vast demand, and scale up the necessary response to deliver the best results. Over recent years a number of global health initiatives have been launched such as Roll Back Malaria, Massive Effort and Stop TB. Global coalitions have been established such as the Global Alliance on Vaccines and Immunisation (GAVI), the International AIDS Vaccine Initiative (IAVI) and now the new Global TB Fund.

Each new initiative has raised attention for a specific health outcome or specific products. They have all led to concerns that if interventions are not carefully designed, resources could be diverted from the long-term commitment to the development of effective health policies and systems. In addition, each new Global Health Initiative creates an increasing management challenge for developing countries unless it is carefully co-ordinated at country level.

In spite of all these efforts, massive development assistance towards better health outcomes for the poor is still needed. We know this and we know that this additional assistance, both private and public, cannot be

delivered on an adequate scale through existing modalities, which often lead to significant hold up of funds in donor and government systems.

Following the G8 2000 discussions a working group consisting of the Commission, the UK, US and Canada, was tasked to explore opportunities to increase and accelerate resource flows, reduce transaction costs for donors and recipient countries and to work in ways that strengthen health strategies and provide better health outcomes through a comprehensive approach. The result is an initial proposal to establish a truly Global Health Partnership. A number of subsequent meetings took place and will continue to take place on the topic.

The Commission is a serious partner in these discussions. Within the Union and at the level of the G8 we have mobilised a strong momentum with an ambitious Programme for Action to accelerate the response to communicable diseases[1]. I will not go into presenting our Programme for Action to you today. Most of you have read the document or were somehow involved or consulted.

The main part of EC financial support for the Programme for Action, and for Health in general, is through country programming, sector and budget support. We have spent more than Euro 4.2 billion on health, AIDS and population programmes for developing countries during the past 10 years, and we will remain committed to increasing the focus on this area. In fact, health and education in developing countries, has become one of the key priorities for the Commission for the year 2002 and we need to find modalities for refocusing resources from areas which may be less relevant for poverty reduction.

The Commission is currently heavily involved in the programming process of financial allocations for the 9th EDF Fund for all African, Caribbean and Pacific countries. There are several routes to take for the EC to increase and improve the part of the development budget devoted to health and education. One is additional debt relief, another is related to increased ODA for health.

A number of the 49 LDCs have been deemed eligible for greater debt relief from the World Bank and IMF, under revised HIPC 2 criteria. As said earlier, countries need to develop a PRSP to qualify for debt relief. To the extend that debt relief frees up government funds to be used for non-debt payment purposes, it creates the potential for additional spending on the social sectors, including health. Under the HIPC initiative we are talking about USD 34 billion. Within the G8 some partners are proposing to increase the share of ODA and commercial debt that can be cancelled by 67% to 90% or more. Discussions on these initiatives are ongoing and results will be presented at the next G8 Summit in Genova.

Now back to the discussions on a Global Health Partnership. For such a partnership to be effective we always felt that the resources -money, commodities and technical assistance-, once they become available, need to be delivered through faster track, transparent and accountable procedures with decision-making at the country level. Resources must be clearly linked to results and to performance. We also believe that an effective response to the major communicable diseases needs action beyond public services.

In our view global partnerships are not *the* solution but only an essential part of a number of solutions to health crises in developing countries. In our thinking following the policy statements made by our Commissioners, we are now clearer on our conditions for possible success.

First, an efficient and co-ordinated financing mechanism at country level (budget support, SWAp, others) needs to be in place, or at least the political commitment to work on such basis needs to be given by the developing countries' authorities.

Second, a real commitment from the industry to a market based tiered pricing system is an absolute must. It seems that we are not very far from such a system, giving the decreased pricing of pharmaceuticals currently announced. Third, we would like to see a coherent and secure global financing system in place. Lastly, we want to further work towards progress with all partners and stakeholders around the framework set during the High Level Round Table in September 2000. We feel that this event was a major step in the

[1] COM (2001) 96 Programme for Action: accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction.

right direction of further elaborating a mechanism for behavioural standards and principles for all stakeholders involved.

One of the concerns our framework should cover is, for example, the one currently expressed by some in terms of incentives for new pharmaceuticals. This issue has been preoccupying me ever since I started working on global health. We need to get a proper financing mechanism in place for the development of new global public goods such as an AIDS or malaria vaccine. We are looking into the Orphan Drug Regulation of December 1999 and social venture capital with a view to ensuring that investment in the development of drugs also flows in the direction of priority medicines for the diseases of the developing world.

You will all agree with me that reducing the pricing of key pharmaceuticals is just one of the angles to tackle. Trade is a lever for economic growth in poor countries, only if it is just and fair. We need to have fair international rules and strong international institutions to tie together private capital and trading opportunities in order to improve the life of the poor. I do not intend to discuss here the role of WTO and the TRIPs Agreement, I just want to reiterate, as clearly stated in our Programme for Action, that all WTO members should be able to use the full flexibility offered by the TRIPs Agreement.

So this is the global debate I think we need and we are having already in different fora. We need to get more partners on board, not least the developing countries themselves. We need to combine all efforts together to ensure that what needs to be done will be done. We know where the problems are, but we still do not have a strong international system focussed on the diseases of the poor. We clearly need to improve our methods. Global partnerships, the European Union, the United States, Canada, Japan, the United Nations, the World Bank and the IMF, the Development Banks, all development agencies, civil society, the private sector, need to collaborate to support governments that are committed to providing good health for their poorest populations.